



Facility Name & ID Number Applewood Nursing & Rehab Center, Llc# 0046151 Report Period Beginning: 02/01/03 Ending: 12/31/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>115</u>	Skilled (SNF)	<u>115</u>	<u>38,410</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>115</u>	TOTALS	<u>115</u>	<u>38,410</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>21,072</u>	<u>6,074</u>	<u>7,962</u>	<u>35,108</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,072</u>	<u>6,074</u>	<u>7,962</u>	<u>35,108</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 91.40%

D. How many bed-hold days during this year were paid by Public Aid?

354 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 2/1/2003

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 2/1/2003 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 115 and days of care provided 7,717Medicare Intermediary Riverbend Government Benefits Administrator

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Applewood Nursing &amp; Rehab Center, LLC

# 0046151

Report Period Beginning: 02/01/03

Ending: 12/31/03

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	185,298	29,839	10,427	225,564		225,564	(9,542)	216,022			1
2	Food Purchase		136,256		136,256		136,256	6,351	142,607			2
3	Housekeeping	108,547	23,679		132,226		132,226	(1,089)	131,137			3
4	Laundry	39,778	12,308		52,086		52,086	(323)	51,763			4
5	Heat and Other Utilities			84,764	84,764		84,764	920	85,684			5
6	Maintenance	62,218		36,595	98,813		98,813	3,126	101,939			6
7	Other (specify):*							1,334	1,334			7
8	<b>TOTAL General Services</b>	395,841	202,082	131,786	729,709		729,709	778	730,487			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			11,000	11,000		11,000		11,000			9
10	Nursing and Medical Records	1,593,215	114,316	124,099	1,831,630		1,831,630	(18,541)	1,813,089			10
10a	Therapy	76,159	1,955		78,114		78,114	311	78,425			10a
11	Activities	56,153	16,044	917	73,114		73,114	17	73,131			11
12	Social Services	109,120		4,311	113,431		113,431	5,327	118,758			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							2,507	2,507			15
16	<b>TOTAL Health Care and Programs</b>	1,834,647	132,315	140,327	2,107,289		2,107,289	(10,379)	2,096,910			16
	<b>C. General Administration</b>											
17	Administrative	72,885			72,885		72,885	6,998	79,883			17
18	Directors Fees											18
19	Professional Services			122,193	122,193		122,193	(85,647)	36,546			19
20	Dues, Fees, Subscriptions & Promotions			13,409	13,409		13,409	(2,654)	10,755			20
21	Clerical & General Office Expenses	86,765	13,764	95,920	196,449		196,449	29,923	226,372			21
22	Employee Benefits & Payroll Taxes			403,401	403,401		403,401	(5,412)	397,989			22
23	Inservice Training & Education			17	17		17		17			23
24	Travel and Seminar			1,157	1,157		1,157	1,246	2,403			24
25	Other Admin. Staff Transportation			1,717	1,717		1,717		1,717			25
26	Insurance-Prop.Liab.Malpractice			101,103	101,103		101,103	760	101,863			26
27	Other (specify):*							10,641	10,641			27
28	<b>TOTAL General Administration</b>	159,650	13,764	738,917	912,331		912,331	(44,145)	868,186			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,390,138	348,161	1,011,030	3,749,329		3,749,329	(53,746)	3,695,583			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

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Facility Name & ID Number      Applewood Nursing & Rehab Center, Llc      #0046151      Report Period Beginning:      02/01/03      Ending:      12/31/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			1,944	1,944		1,944	64,549	66,493			30
31	Amortization of Pre-Op. & Org.			9,909	9,909		9,909	2,155	12,064			31
32	Interest			16,232	16,232		16,232	126,560	142,792			32
33	Real Estate Taxes			277,981	277,981		277,981	(38,042)	239,939			33
34	Rent-Facility & Grounds			307,817	307,817		307,817	(305,556)	2,261			34
35	Rent-Equipment & Vehicles			6,940	6,940		6,940	1,226	8,166			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			620,823	620,823		620,823	(149,108)	471,715			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		340,611	533,525	874,136		874,136	(9,677)	864,459			39
40	Barber and Beauty Shops			7,755	7,755		7,755	(7,755)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,616	57,616		57,616		57,616			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		340,611	598,896	939,507		939,507	(17,432)	922,075			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,390,138	688,772	2,230,749	5,309,659		5,309,659	(220,286)	5,089,373			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 5

Facility Name &amp; ID Number Applewood Nursing &amp; Rehab Center, Llc

# 0046151

Report Period Beginning: 02/01/03

Ending: 12/31/03

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(439)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(535)	30		9
10	Interest and Other Investment Income	(7)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(232)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(44,000)	21		24
25	Fund Raising, Advertising and Promotional	(3,386)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(82,100)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (130,699)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(89,587)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (89,587)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (220,286)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS			Page 5A
Appletwood Nursing & Rehab Center, LLC			
ID# 0004551			
Report Period Beginning:	02/01/03		
Ending:	12/31/03		
NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1	Duty Duty Income	5 (102)	10 1
2	Barber & Beauty	6 (750)	49 2
3	Bank Charges	7 (3,446)	23 3
4	Bldg Co - Bank Charges	8 (706)	23 4
5	Bldg Co - Amortization of Goodwill	9 (57,813)	23 5
6	Incontinence Revenue	10 (13,227)	19 6
7	Non-allowable Legal	19 (351)	19 7
8			8
9			9
10			10
11			11
12			12
13			13
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91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101	Total	(82,100)	101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Applewood Nursing &amp; Rehab Center, Llc

# 0046151

Report Period Beginning:

02/01/03

Ending:

12/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary			30		2,008	(10,400)		(1,180)				(9,542)	1
2	Food Purchase	(671)		(54)			7,076						6,351	2
3	Housekeeping					576			(1,665)				(1,089)	3
4	Laundry								(323)				(323)	4
5	Heat and Other Utilities			920									920	5
6	Maintenance			960	41	2,110	15						3,126	6
7	Other (specify):*				343	582	409						1,334	7
8	<b>TOTAL General Services</b>	(671)		1,856	384	5,276	(2,900)		(3,167)				778	8
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(12,329)		122	(4,767)	6,665			(8,232)				(18,541)	10
10a	Therapy					311							311	10a
11	Activities			17									17	11
12	Social Services				5,234	93							5,327	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				1,647	860							2,507	15
16	<b>TOTAL Health Care and Programs</b>	(12,329)		139	2,114	7,929			(8,232)				(10,379)	16
	<b>C. General Administration</b>													
17	Administrative					6,705	293						6,998	17
18	Directors Fees													18
19	Professional Services	(351)		(85,392)			96						(85,647)	19
20	Fees, Subscriptions & Promotions	(3,386)		705			27						(2,654)	20
21	Clerical & General Office Expenses	(48,152)	706	10,228		66,517	624						29,923	21
22	Employee Benefits & Payroll Taxes				(4,122)			(809)	(482)				(5,412)	22
23	Inservice Training & Education													23
24	Travel and Seminar			442			804						1,246	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			760									760	26
27	Other (specify):*				1,594	9,047							10,641	27
28	<b>TOTAL General Administration</b>	(51,889)	706	(73,257)	(2,528)	82,269	1,844	(809)	(482)				(44,145)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(64,889)	706	(71,262)	(30)	95,474	(1,056)	(809)	(11,881)				(53,746)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Applewood Nursing & Rehab Center, LLC # 0046151 Report Period Beginning: 02/01/03 Ending: 12/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(535)	60,187	4,897									64,549	30
31	Amortization of Pre-Op. & Org.	(57,513)	59,668										2,155	31
32	Interest	(7)	116,922	9,638			7						126,560	32
33	Real Estate Taxes		(39,408)	1,366									(38,042)	33
34	Rent-Facility & Grounds		(307,817)	2,261									(305,556)	34
35	Rent-Equipment & Vehicles			1,070			156						1,226	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(58,055)</b>	<b>(110,448)</b>	<b>19,232</b>			<b>163</b>						<b>(149,108)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(1,342)		(8,335)				(9,677)	39
40	Barber and Beauty Shops	(7,755)											(7,755)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>	<b>(7,755)</b>					<b>(1,342)</b>		<b>(8,335)</b>				<b>(17,432)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(130,699)</b>	<b>(109,742)</b>	<b>(52,030)</b>	<b>(30)</b>	<b>95,474</b>	<b>(2,235)</b>	<b>(809)</b>	<b>(20,216)</b>				<b>(220,286)</b>	<b>45</b>

Facility Name & ID Number Applewood Nursing & Rehab Center, LLC# 0046151

Report Period Beginning:

02/01/03Ending: 12/31/03

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Applewood Property LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 307,817	Applewood Property LLC		\$	(307,817)	1
2	V	33 Real Estate Tax	277,982	Applewood Property LLC		238,574	(39,408)	2
3	V	21 Bank Charges		Applewood Property LLC		706	706	3
4	V	32 Interest		Applewood Property LLC		116,922	116,922	4
5	V	30 Depreciation		Applewood Property LLC		60,187	60,187	5
6	V	31 Amortization		Applewood Property LLC		59,668	59,668	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 585,799			\$ 476,057	\$ * (109,742)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, LLC# 0046151Report Period Beginning: 02/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$	Care Centers, Inc.	100.00%	\$ 30	\$ 30	15
16	V	05 Utilities		Care Centers, Inc.	100.00%	920	920	16
17	V	06 Maintenance		Care Centers, Inc.	100.00%	960	960	17
18	V	10 Nursing	18	Care Centers, Inc.	100.00%	140	122	18
19	V	11 Activities		Care Centers, Inc.	100.00%	17	17	19
20	V	19 Professional Fees	91,540	Care Centers, Inc.	100.00%	6,148	(85,392)	20
21	V	20 Dues and Subscriptions	-	Care Centers, Inc.	100.00%	705	705	21
22	V	21 Office & Clerical		Care Centers, Inc.	100.00%	10,228	10,228	22
23	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	442	442	23
24	V	26 Insurance		Care Centers, Inc.	100.00%	760	760	24
25	V	30 Depreciation		Care Centers, Inc.	100.00%	4,897	4,897	25
26	V	32 Interest		Care Centers, Inc.	100.00%	9,638	9,638	26
27	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	1,366	1,366	27
28	V	34 Rent - Building		Care Centers, Inc.	100.00%	2,261	2,261	28
29	V	35 Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,070	1,070	29
30	V	25 Bus Reimbursement	-	Care Centers, Inc.	100.00%			30
31	V	02 Food	54	Care Centers, Inc.	100.00%	-	(54)	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 91,612			\$ 39,582	\$ * (52,030)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, LLC# 0046151Report Period Beginning: 02/01/03 Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	06 Maintenance Salary	\$ 2,701	Care Centers, Inc.	100.00%	\$ 2,742	\$ 41
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	343	343
17	V	10 Nursing Salary	9,479	Care Centers, Inc.	100.00%	4,712	(4,767)
18	V	10a Rehab Salary		Care Centers, Inc.	100.00%		
19	V	11 Activity Salary		Care Centers, Inc.	100.00%		
20	V	12 Social Service Salary	3,502	Care Centers, Inc.	100.00%	8,736	5,234
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,647	1,647
22	V	17 Administration Salary		Care Centers, Inc.	100.00%		
23	V	21 Office Salary	12,600	Care Centers, Inc.	100.00%	12,600	
24	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	1,594	1,594
25	V	22 Employee Benefits	4,122	Care Centers, Inc.	100.00%		(4,122)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 32,404			\$ 32,374	\$ * (30)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, LLC# 0046151Report Period Beginning: 02/01/03 Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary Salary	\$	Care Centers, Inc.	100.00%	\$ 2,008	\$ 2,008 15
16	V	03 Housekeeping Salary		Care Centers, Inc.	100.00%	576	576 16
17	V	06 Maintenance Salary		Care Centers, Inc.	100.00%	2,110	2,110 17
18	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	582	582 18
19	V	10 Nursing Salary		Care Centers, Inc.	100.00%	6,665	6,665 19
20	V	10a Rehab Salary		Care Centers, Inc.	100.00%	311	311 20
21	V	12 Social Services Salary		Care Centers, Inc.	100.00%	93	93 21
22	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	860	860 22
23	V	17 Administration Salary		Care Centers, Inc.	100.00%	6,705	6,705 23
24	V	21 Office Salary		Care Centers, Inc.	100.00%	66,517	66,517 24
25	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	9,047	9,047 25
26	V						26
27	V						27
28	V						28
29	V						29
30	V						30
31	V						31
32	V						32
33	V						33
34	V						34
35	V						35
36	V						36
37	V						37
38	V						38
39	Total		\$			\$ 95,474	\$ * 95,474 39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, LLC# 0046151Report Period Beginning: 02/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary	\$ 15,164	Care Centers, Inc. - Health Systems Division	100.00%	\$ 1,621	\$ (13,543)
16	V	02 Food		Care Centers, Inc. - Health Systems Division	100.00%	7,076	7,076
17	V	06 Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	15	15
18	V	17 Administration		Care Centers, Inc. - Health Systems Division	100.00%	293	293
19	V	19 Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	96	96
20	V	20 Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	27	27
21	V	21 Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	624	624
22	V	24 Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	804	804
23	V	32 Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	7	7
24	V	35 Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	156	156
25	V	39 Ancillary Enteral Supplies	5,589	Care Centers, Inc. - Health Systems Division	100.00%	4,247	(1,342)
26	V	01 Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	3,143	3,143
27	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	409	409
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 20,753			\$ 18,518	\$ * (2,235)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, LLC# 0046151Report Period Beginning: 02/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 191,706	\$ 191,706	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	192,515	CCS EMPLOYEE BENEFIT GROUP	100.00%		(192,515)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 192,515			\$ 191,706	\$ * (809)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, LLC# 0046151Report Period Beginning: 02/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 DIETARY	\$ 8,963	XCEL MEDICAL SUPPLY, LLC	100.00%	\$ 7,783	\$ (1,180)
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%		
17	V	03 HOUSEKEEPING	12,647	XCEL MEDICAL SUPPLY, LLC	100.00%	10,982	(1,665)
18	V	04 LAUNDRY	2,452	XCEL MEDICAL SUPPLY, LLC	100.00%	2,129	(323)
19	V	06 REPAIRS & MAINTENANCE		XCEL MEDICAL SUPPLY, LLC	100.00%		
20	V	10 NURSING	62,538	XCEL MEDICAL SUPPLY, LLC	100.00%	54,306	(8,232)
21	V	10A THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%		
22	V	12 SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
24	V	22 EMPLOYEE BENEFITS	3,661	XCEL MEDICAL SUPPLY, LLC	100.00%	3,179	(482)
25	V	39 ANCILLARY	63,324	XCEL MEDICAL SUPPLY, LLC	100.00%	54,989	(8,335)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 153,585			\$ 133,369	\$ * (20,216)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, LLC# 0046151Report Period Beginning: 02/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V					\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, LLC# 0046151Report Period Beginning: 02/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, LLC# 0046151Report Period Beginning: 02/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name & ID Number Applewood Nursing & Rehab Center, Llc # 0046151 Report Period Beginning: 02/01/03 Ending: 12/31/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	1.00%	See Attached	0.75	136.00%		\$		1
2	Adam Vales	Owner	Clerical	11.00%	See Attached	0.99	2.48%	CCS-VEBA	767	22-7	2
3	Mark Steinberg	Relative	Administrative	0	See Attached	1.18	2.34%	CCI-salary	930	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,697		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, Llc # 0046151 Report Period Beginning: 02/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, Llc # 0046151 Report Period Beginning: 02/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.  
 Street Address 2202 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary	Patient Days	1,764,895	42	\$ 1,527	\$	35,108	\$ 30	1
2	05 Utilities	Patient Days	1,764,895	42	46,229		35,108	920	2
3	06 Maintenance	Patient Days	1,764,895	42	48,251		35,108	960	3
4	10 Nursing	Patient Days	1,764,895	42	7,018		35,108	140	4
5	11 Activities	Patient Days	1,764,895	42	838		35,108	17	5
6	19 Professional Fees	Patient Days	1,764,895	42	309,074		35,108	6,148	6
7	20 Dues and Subscriptions	Patient Days	1,764,895	42	35,428		35,108	705	7
8	21 Office & Clerical	Patient Days	1,764,895	42	523,091		35,108	10,228	8
9	24 Travel and Seminar	Patient Days	1,764,895	42	22,233		35,108	442	9
10	26 Insurance	Patient Days	1,764,895	42	38,230		35,108	760	10
11	30 Depreciation	Patient Days	1,764,895	42	246,194		35,108	4,897	11
12	32 Interest	Patient Days	1,764,895	42	484,531		35,108	9,638	12
13	33 Real Estate Taxes	Patient Days	1,764,895	42	68,681		35,108	1,366	13
14	34 Rent - Building	Patient Days	1,764,895	42	113,677		35,108	2,261	14
15	35 Rent - Equipment & Auto	Patient Days	1,764,895	42	53,777		35,108	1,070	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,998,780	\$		\$ 39,582	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, Llc # 0046151 Report Period Beginning: 02/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.  
 Street Address 2202 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06 Maintenance Salary	Direct Cost			213,393	213,393		2,742	1
2	07 Emp. Ben. - Gen. Serv.	Direct Cost			26,918			343	2
3	10 Nursing Salary	Direct Cost			976,718	976,718		4,712	3
4	10a Rehab Salary	Direct Cost			103,898	103,898			4
5	11 Activity Salary	Direct Cost			10,902	10,902			5
6	12 Social Service Salary	Direct Cost			306,863	306,863		8,736	6
7	15 Emp. Ben. - Healthcare	Direct Cost			174,348			1,647	7
8	17 Administration Salary	Direct Cost			1,191,200	1,191,200			8
9	21 Office Salary	Direct Cost			698,886	698,886		12,600	9
10	27 Emp. Ben. - Gen. Admin.	Direct Cost			238,998			1,594	10
11	22 Employee Benefits								11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,942,124	\$ 3,501,860		\$ 32,374	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, Llc # 0046151 Report Period Beginning: 02/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.  
 Street Address 2202 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary Salary	Patient Days	1,764,895	42	100,923	100,923	35,108	2,008	1
2	03 Housekeeping Salary	Patient Days	1,764,895	42	28,979	28,979	35,108	576	2
3	06 Maintenance Salary	Patient Days	1,764,895	42	106,088	106,088	35,108	2,110	3
4	07 Emp. Ben. - Gen. Serv.	Patient Days	1,764,895	42	29,264		35,108	582	4
5	10 Nursing Salary	Patient Days	1,764,895	42	335,028	335,028	35,108	6,665	5
6	10a Rehab Salary	Patient Days	1,764,895	42	15,649	15,649	35,108	311	6
7	12 Social Services Salary	Patient Days	1,764,895	42	4,661	4,661	35,108	93	7
8	15 Emp. Ben. - Healthcare	Patient Days	1,764,895	42	43,235		35,108	860	8
9	17 Administration Salary	Patient Days	1,764,895	42	337,043	337,043	35,108	6,705	9
10	21 Office Salary	Patient Days	1,764,895	42	3,343,864	3,343,864	35,108	66,517	10
11	27 Emp. Ben. - Gen. Admin.	Patient Days	1,764,895	42	454,813		35,108	9,047	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,799,547	\$ 4,272,235		\$ 95,474	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, Llc # 0046151 Report Period Beginning: 02/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.  
 Street Address 2202 West Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905-3000  
 Fax Number ( 847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary	Billable Income	2,073,579		138,556		24,265	1,621	1
2	02 Food	Billable Income	2,073,579		852,614		24,265	7,076	2
3	06 Maintenance	Billable Income	2,073,579		1,311		24,265	15	3
4	17 Administration	Billable Income	2,073,579		25,000		24,265	293	4
5	19 Professional Fees	Billable Income	2,073,579		8,170		24,265	96	5
6	20 Dues & Subscriptions	Billable Income	2,073,579		2,312		24,265	27	6
7	21 Office & Clerical	Billable Income	2,073,579		53,285		24,265	624	7
8	24 Travel & Seminar	Billable Income	2,073,579		68,680		24,265	804	8
9	32 Interest Expense	Billable Income	2,073,579		571		24,265	7	9
10	35 Rent - Equipment & Auto	Billable Income	2,073,579		13,336		24,265	156	10
11	39 Ancillary Enteral Supplies	Billable Income	2,073,579		114,955		24,265	4,247	11
12	01 Dietary - Salary	Billable Income	2,073,579		268,554	268,554	24,265	3,143	12
13	07 Emp. Ben. - Gen. Serv.	Billable Income	2,073,579		34,942		24,265	409	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,582,287	\$ 268,554		\$ 18,518	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, Llc # 0046151 Report Period Beginning: 02/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.  
 Street Address 4101 W. MAIN ST.  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 191,706	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 191,706	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, Llc # 0046151 Report Period Beginning: 02/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization XCEL MEDICAL SUPPLY, LLC  
 Street Address 2201 MAIN STREET  
 City / State / Zip Code EVANSTON, IL 60202  
 Phone Number ( 847)328-7600  
 Fax Number ( 847)328-7615

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 DIETARY	Direct Allocation			\$	\$		\$ 7,783	1
2	02 FOOD	Direct Allocation							2
3	03 HOUSEKEEPING	Direct Allocation						10,982	3
4	04 LAUNDRY	Direct Allocation						2,129	4
5	06 REPAIRS & MAINTENANCE	Direct Allocation							5
6	10 NURSING	Direct Allocation						54,306	6
7	10A THERAPY	Direct Allocation							7
8	12 SOCIAL SERVICE	Direct Allocation							8
9	21 CLERICAL & GENERAL OFFICE	Direct Allocation							9
10	22 EMPLOYEE BENEFITS	Direct Allocation						3,179	10
11	39 ANCILLARY	Direct Allocation						54,989	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 133,369	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, Llc # 0046151 Report Period Beginning: 02/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number (\_\_\_\_\_  
 Fax Number (\_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, Llc # 0046151 Report Period Beginning: 02/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, Llc # 0046151 Report Period Beginning: 02/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related Long-Term													
1	LaSalle Bank		X	Mortgage			\$	2,570,900			\$	116,922	1	
2													2	
3													3	
4													4	
5	See Supplemental Schedule												5	
	Working Capital													
6	LaSalle Bank		X	Line of Credit				660,139				16,232	6	
7	Genesis (old owners)		X					177,606					7	
8	See Supplemental Schedule							23,050					8	
9	TOTAL Facility Related						\$	3,431,695				\$	133,154	9
	B. Non-Facility Related*													
10													10	
11	Interest Income											(7)	11	
12	Alloc from Care Centers											9,645	12	
13	See Supplemental Schedule												13	
14	TOTAL Non-Facility Related						\$					\$	9,638	14
15	TOTALS (line 9+line14)						\$	3,431,695				\$	142,792	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.     \$ N/A     Line #           

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)     SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	Shareholders	X					\$	\$ 23,050			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital							23,050				14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

- \* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT
- \*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Applewood Nursing & Rehab Center, Llc**# **0046151** Report Period Beginning: **02/01/03** Ending: **12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ (38,042)	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (38,042)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 277,981	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 239,939	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998 175,858 8		
	1999 152,922 9		
	2000 186,574 10		
	2001 198,994 11		
	2002 264,741 12		
<b>2003 Accrual = 2002 Tax \$264,741 x 1.05 = \$277,981</b>		13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
<b>Line 2 includes an allocation from Care Centers of \$1366</b>		14	PLUS APPEAL COST FROM LINE 5 \$ 14
<b>The credit on line 2 represents a credit from the prior owners for January 2003 of \$39,408, less CCI allocation of \$1,366.</b>		15	LESS REFUND FROM LINE 6 \$ 15
		16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Applewood Nursing & Rehab Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046151

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>31-22-114-023-0000</u>	<u>Long Term Care Property</u>	\$ <u>15,228.87</u>	\$ <u>15,228.87</u>
2. <u>31-22-114-024-0000</u>	<u>Long Term Care Property</u>	\$ <u>231,702.64</u>	\$ <u>231,702.64</u>
3. <u>31-22-114-025-0000</u>	<u>Long Term Care Property</u>	\$ <u>4,719.86</u>	\$ <u>4,719.86</u>
4. <u>31-22-114-026-0000</u>	<u>Long Term Care Property</u>	\$ <u>13,089.76</u>	\$ <u>13,089.76</u>
5. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>68,681.49</u>	\$ <u>1,366.24</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>333,422.62</u></u>	\$ <u><u>266,107.37</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?   X   YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Applewood Nursing & Rehab Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046151

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>                    </u>	\$ <u>                    </u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?            YES            NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A.
 Square Feet:
 34,449

B. General Construction Type:
 Exterior
 Brick
 Frame
 Steel Stud
 Number of Stories
 1

C.
 Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.
 Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.
 List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F.
 Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☒ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred:
 80,446

2. Number of Years Over Which it is Being Amortized:
 various

3. Current Period Amortization:
 12,064

4. Dates Incurred:
 2003

Nature of Costs:
 Organization Costs, Loan Closing Costs, Settlement Charges, HUD Appraisal

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	191,664	2003	\$ 223,625	1
2	Alloc from 2201 Main LLC			10,113	2
3	TOTALS	191,664		\$ 233,738	3

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10								-		-	9
11								-		-	10
12								-		-	11
13								-		-	12
14								-		-	13
15								-		-	14
16								-		-	15
17								-		-	16
18								-		-	17
19								-		-	18
20								-		-	19
21								-		-	20
22								-		-	21
23								-		-	22
24								-		-	23
25								-		-	24
26								-		-	25
27								-		-	26
28								-		-	27
29								-		-	28
30								-		-	29
31								-		-	30
32								-		-	31
33								-		-	32
34								-		-	33
35								-		-	34
36								-		-	35

\*Total beds on this schedule must agree with page 2.  
 \*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total  
 SEE ACCOUNTANTS' COMPILATION REPORT

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		1,979,167	46,185		46,185		46,185	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		38,254	1,278		1,278		1,361	68
69	Financial Statement Depreciation			440			(440)		69
70	TOTAL (lines 4 thru 69)		\$ 2,017,421	\$ 47,903		\$ 47,463	\$ (440)	\$ 47,546	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 12B

Facility Name &amp; ID Number Applewood Nursing &amp; Rehab Center, Llc

# 0046151

Report Period Beginning:

02/01/03

Ending:

12/31/03

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,017,421	\$ 47,903		\$ 47,463	\$ (440)	\$ 47,546	1
2	Avary	2003	4,987		20	208	208	208	2
3	Boiler Repair	2003	734		20	24	24	24	3
4	Walk In Cooler Repair	2003	1,491		20	50	50	50	4
5	Roof Repair	2003	2,000		20	67	67	67	5
6	Condensing Unit Replacement	2003	1,522		20	44	44	44	6
7	Condenser Repairs	2003	566		20	17	17	17	7
8	Recirculating Pump	2003	663		20	19	19	19	8
9	Hot Water Heater Repairs	2003	1,028		20	30	30	30	9
10	Hot Water Heater Repairs	2003	1,131		20	33	33	33	10
11	Phone Line Repair	2003	608		20	15	15	15	11
12	Six Motor Fans (Showers)	2003	1,154		20	29	29	29	12
13	Alarms	2003	663		20	11	11	11	13
14	Water Heater Repair	2003	533		20	9	9	9	14
15	Hot Water Heater Repair	2003	565		20	7	7	7	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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17									17
18									18
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21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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17									17
18									18
19									19
20									20
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1 Totals from Page 12D, Carried Forward		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34 TOTAL (lines 1 thru 33)		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109		34

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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17									17
18									18
19									19
20									20
21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1 Totals from Page 12J, Carried Forward		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34 TOTAL (lines 1 thru 33)		\$ 2,035,066	\$ 47,903		\$ 48,026	\$ 123	\$ 48,109		34

Facility Name &amp; ID Number Applewood Nursing &amp; Rehab Center, Llc

# 0046151

Report Period Beginning:

02/01/03

Ending:

12/31/03

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment.** (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	115		2003	1967	\$ 1,942,991	\$ 44,527		\$ 44,527	\$	\$ 44,527	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements		2003		36,176	1,658		1,658		1,658	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

12/31/03

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)												
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.												
	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9		
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	2201 Main LLC		2002		\$ 13,937	\$ 348		\$ 348	\$	\$ 377	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	2201 Main LLC Allocation			2002	12,904	645		645		699	9	
10				2003	11,413	285		285		285	10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

\*Total beds on this schedule must agree with page 2.  
 \*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total  
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 38,254	\$ 1,278		\$ 1,278	\$	\$ 1,361	70

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 25,968	\$ 1,886	\$ 1,886	\$	10	\$ 21,471	71
72	Current Year Purchases	166,340	15,673	15,015	(658)	10	15,015	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 192,308	\$ 17,559	\$ 16,901	\$ (658)		\$ 36,486	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Alloc from Care Centers			\$ 13,401	\$ 1,457	\$ 1,457	\$	5	\$ 11,294	76
77	Alloc from Care Centers			1,091	109	109		5	109	77
78										78
79										79
80	TOTALS			\$ 14,492	\$ 1,566	\$ 1,566	\$		\$ 11,403	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,475,604	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 67,028	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 66,493	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (535)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 95,998	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocation from Care Centers Inc.				2,261			5
6								6
7	TOTAL				\$ 2,261			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 8,166 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ \_\_\_\_\_

13. /2005 \$ \_\_\_\_\_

14. /2006 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
 SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 77,166	\$		\$ 77,166	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			10,608			10,608	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			445,751			445,751	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				234,664		234,664	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						105,947		105,947	13
14	TOTAL			\$		\$ 533,525	\$ 340,611		\$ 874,136	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 244,140	\$ 256,979	1
2	Cash-Patient Deposits	14,207	14,207	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,065,436	1,065,436	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,356	17,356	6
7	Other Prepaid Expenses	16,763	16,763	7
8	Accounts Receivable (owners or related parties)	445,429	445,429	8
9	Other(specify): <a href="#">See Attached Schedule</a>	81,000	155,255	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,884,331	\$ 1,971,425	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		223,625	13
14	Buildings, at Historical Cost		1,942,991	14
15	Leasehold Improvements, at Historical Cost	8,741	44,917	15
16	Equipment, at Historical Cost	19,169	171,920	16
17	Accumulated Depreciation (book methods)	(1,944)	(1,944)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		941,120	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		42,942	22
23	Other(specify): <a href="#">See Attached Schedule</a>		27,595	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 25,966	\$ 3,393,166	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,910,297	\$ 5,364,591	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 319,871	\$ 319,873	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,007	14,007	28
29	Short-Term Notes Payable	660,139	860,795	29
30	Accrued Salaries Payable	216,771	216,771	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,294	15,294	31
32	Accrued Real Estate Taxes(Sch.IX-B)	277,981	277,981	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Attached Schedule</a>	47,045	500,184	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,551,108	\$ 2,204,905	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,570,900	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 2,570,900	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,551,108	\$ 4,775,805	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 359,189	\$ 588,786	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,910,297	\$ 5,364,591	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>359,189</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 359,189</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 359,189</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 19

Facility Name &amp; ID Number Applewood Nursing &amp; Rehab Center, Llc

# 0046151

Report Period Beginning: 02/01/03

Ending:

12/31/03

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,370,516	1
2	Discounts and Allowances for all Levels	(2,343,754)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,026,762	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,222,557	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,222,557	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	10,173	13
14	Non-Patient Meals	439	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	227,076	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,714	19
20	Radiology and X-Ray	5,084	20
21	Other Medical Services	140,743	21
22	Laundry	2,192	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 419,421	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	7	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	101	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 101	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,668,848	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	729,709	31
32	Health Care	2,107,289	32
33	General Administration	912,331	33
	<b>B. Capital Expense</b>		
34	Ownership	620,823	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	881,891	35
36	Provider Participation Fee	57,616	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,309,659	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	359,189	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 359,189	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Applewood Nursing & Rehab Center, LLC# 0046151Report Period Beginning: 02/01/03Ending: 12/31/03

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,831	1,904	\$ 57,524	\$ 30.21	1
2	Assistant Director of Nursing	1,536	1,608	42,596	26.49	2
3	Registered Nurses	16,523	18,542	457,632	24.68	3
4	Licensed Practical Nurses	13,906	15,304	295,322	19.30	4
5	Nurse Aides & Orderlies	60,925	68,457	717,947	10.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,179	4,650	76,159	16.38	8
9	Activity Director	2,085	2,345	33,945	14.48	9
10	Activity Assistants	2,734	3,065	22,208	7.25	10
11	Social Service Workers	5,157	5,754	109,120	18.96	11
12	Dietician					12
13	Food Service Supervisor	1,861	1,920	28,172	14.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,287	17,248	157,126	9.11	15
16	Dishwashers					16
17	Maintenance Workers	3,517	4,146	62,218	15.01	17
18	Housekeepers	10,708	12,387	108,547	8.76	18
19	Laundry	3,841	4,545	39,778	8.75	19
20	Administrator	1,686	1,907	72,885	38.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,018	7,679	86,765	11.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,727	1,972	22,194	11.25	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	154,521	173,433	\$ 2,390,138 *	\$ 13.78	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	229	\$ 9,952	01-03	35
36	Medical Director	monthly	11,000	09-03	36
37	Medical Records Consultant	monthly	2,752	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	3,795	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	917	11-03	44
45	Social Service Consultant	13	809	12-03	45
46	Other(specify)				46
47	<u>Passover Consultant</u>		125	01-03	47
48	<u>CCI - see attached</u>		13,331		48
49	TOTAL (lines 35 - 48)	261	\$ 42,681		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	432	\$ 23,776	10-03	50
51	Licensed Practical Nurses	2,159	84,297	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,591	\$ 108,073		53

SEE ACCOUNTANTS' COMPILATION REPORT

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount
Dianne O'Connor	Administrator	0	\$ 72,885	Workers' Compensation Insurance	\$ 86,198	IDPH License Fee	\$ 797
				Unemployment Compensation Insurance	41,611	Advertising: Employee Recruitment	3,686
				FICA Taxes	163,356	Health Care Worker Background Check	
				Employee Health Insurance	96,143	(Indicate # of checks performed 85 )	1,832
				Employee Meals		Dues & Subscriptions	3,108
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	600
						Advertising & Promotion	3,386
						Allocation from Care Centers	732
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Physicals	7,193	Less: Public Relations Expense	( )
(List each licensed administrator separately.)			\$ 72,885	Christmas Expense	2,171	Non-allowable advertising	(3,386)
B. Administrative - Other				Misc. Employee Welfare	1,317	Yellow page advertising	( )
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)	
			\$			\$ 10,755	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 397,989	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
C. Professional Services				Description	Line #	Amount	G. Schedule of Travel and Seminar**
Vendor/Payee	Type		Amount				Description
Frost, Ruttenberg & Rothblatt	Accounting	\$	16,500				Amount
Care Centers Inc.	Bookkeeping Service		15,640				Out-of-State Travel
CT Corporation	Legal (adjusted page 5)		351				\$
Jean Adams	Legal		450				
Guardianship Services Assoc.	Legal		1,036				In-State Travel
National Datacare	Data Processing		756				
Achieve Healthcare	Data Processing		2,100				
Ivans	Data Processing		210				
ADP, Inc.	Payroll Processing		5,212				Seminar Expense
Site Builders	Data Processing		11				1,157
TBT Enterprises	Unemployment Fee		94				Allocation from Care Centers
See Supplemental Schedule			79,833				1,246
TOTAL (agree to Schedule V, line 19, column 3)							
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 122,193				Entertainment Expense
				TOTAL	\$	( )	
						(agree to Sch. V, line 24, col. 8)	
						TOTAL	\$ 2,403

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center, Llc

STATE OF ILLINOIS

# 0046151

Report Period Beginning:

02/01/03

Ending:

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Health Care Assoc. \$904
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 77,218 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 57,616  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 439
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.